

Queenscourt Hospice

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Inspection report

Queenscourt Hospice
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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

This announced inspection of Queenscourt Hospice took place on 31 May and 1 & 2 June 2016.

Queenscourt Hospice is a local charity that provides ten beds for acute specialist palliative care and support for the people of Southport, Formby and West Lancs. At the time of our inspection nine people were receiving specialist palliative care and support as an in-patient. The service also provides support for families, friends and carers of people using the services of the hospice. Palliative care means the hospice cares for people with serious illnesses, enabling them to achieve the best possible quality of life at each new stage. The in-patient unit had two wards (Woodside and Lakeside) and two single en-suite rooms. The service provision included Queenscourt at Home service, an in-patient unit and Queenscourt Connect. Queenscourt Connect provides day care and also a therapy service.

There was a registered manager in post. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run'.

The organisational structure included the director of clinical services (DCS) who was also the registered manager, the medical and education director (MED) who held the position of consultant in palliative medicine and there was a director of non-clinical services (DNCS). The organisation had a responsible individual who was the main point of contact with us, the Care Quality Commission, (CQC).

People we spoke with, family members and staff spoke positively regarding the overall management of the hospice and the leadership qualities of the senior management team. A person told us, "The staff team are brilliant."

Family and carers' support was seen as important part of the overall care provision and feedback from relatives we spoke with was very positive. A relative said, "The support we have all had has been wonderful, I could not ask for more." Formal feedback included the provision of surveys and feedback was very positive across all hospice departments.

The quality of the service was assessed and monitored regularly by a series of audits (checks) on the service provision to help monitor standards and drive forward improvements. We saw there was emphasis on working in partnership with external organisations, including other hospices and taking part in research based work and projects to evidence best possible outcomes for people who need end of life care.

Staff had a good knowledge of what constituted abuse and how they would report an alleged incident. Safeguarding policies and procedures were in place along with local authority guidelines for staff to follow.

People using the services of the hospice were protected against the risks associated with the use and

management of medicines. Medicines were audited (checked) to ensure they were managed safely. Symptom control including pain management was seen as a priority.

Risk assessments were in place to ensure people's health and safety. The risk assessments helped to help mitigate those risks and to protect them from unnecessary harm. There was a robust system in place to assess and monitor accidents and incidents. Incidents were analysed to minimise the risk of re-occurrence.

People were supported by sufficient numbers of staff to provide care and support in accordance with individual need. There was a flexible approach to adjusting the levels of staff required. People who were receiving care on the in-patient unit told us the staffing numbers were very good and assistance was provided promptly when requested.

Staff sought advice and support from health professionals to ensure people received the support they needed it and when requested to optimise their health. Hospice staff included doctors, nurses, physiotherapists, occupations therapists, complementary therapists, social worker, pastoral support, housekeeping and catering team.

Volunteers worked alongside hospice staff. They helped run fund raising events and supported the staff in various roles.

The hospice provides a very relaxed, comfortable and attractive environment which was designed to provide maximum privacy for people on the in-patient unit. The hospice had facilities for families and this included an overnight room and a house for people to stay in. The hospice grounds were landscaped and provided a tranquil setting for people to enjoy the peaceful surroundings.

A high standard of cleanliness was maintained at the hospice. Systems and processes were in place to monitor standards of hygiene and control of infection.

Recruitment procedures were robust to ensure staff and volunteers were suitable to work with vulnerable people.

Systems were in place to maintain the safety of the hospice. This included fire prevention, health and safety checks of equipment and the building and general maintenance.

We saw staff had access to a good training programme and support with their job role. The formal training programme for staff included palliative and end of life qualifications as part of their professional learning and development. A staff member said, "The training programme provides us with good learning opportunities."

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to hospices. Staff were trained in the principles of the Mental Capacity Act 2005 (MCA) and the DoLS and were knowledgeable in the main principles of the MCA that they applied in practice. They assessed people's mental capacity when necessary and when applicable they held meetings to make decisions on their behalf and in their best interest. This meant that people's rights were protected and respected. People's consent was documented electronically to evidence their inclusion around their care and treatment.

Feedback about the meals was very good and emphasis was placed on accommodating people's dietary needs and preferences so that the dining experience was enjoyable. People said, "The meals are so nicely served and so much choice" and "It's like hotel food in all respects." People had access to a menu which

offered a good choice of hot and cold meals. Refreshments were available twenty four hours a day.

Staff were very caring, supportive and polite when helping people. Staff had time to listen and to spend time with people throughout the day so that they go to know them well. A person said, "Everyone makes so much time for you, it does help so much."

People told us they were involved with their care and treatment and everything was fully explained to them. People told us they had time to ask questions, had confidence in the staff team's ability to care for them.

We saw people had a plan of care which provided information about their medical, physical, emotional and social care and specific wishes were recorded in advance care plans (ACPs). Care plans were stored electronically, and we saw those for in-patients were reviewed and updated on a daily basis.

People and their families were given plenty of information about the hospice and leaflets were available regarding support services/organisations and also medical conditions and symptoms people may experience.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

The local authority's and the service's safeguarding process were followed to protect people from abuse.

People were protected against the risks associated with the use and management of medicines. Pain management was seen as a priority.

Risk assessments were in place to ensure people's health and safety. Incidents and accidents were logged and analysed to reduce the risk of re-occurrence.

Staffing numbers were assessed and were adjusted to ensure there were always sufficient numbers of trained, skilled and experienced staff to meet people's needs.

Recruitment processes for new staff were robust to ensure they were suitable to work with vulnerable people. These checks were also carried out for volunteers.

The hospice environment was well maintained. Robust infection control measures were in place.

Is the service effective?

Good 

The service was effective.

Staff sought advice and support from external health professionals when needed to help assure people's health and wellbeing.

Staff followed the principles of the Mental Capacity Act (2005) for people who lacked capacity to make their own decisions. People's capacity to make decisions and give consent was assessed and recorded.

Menus were planned to suit people's individual needs, requirements and preferences. People were offered a good

choice of hot and cold meals.

Staff told us they were supported through induction, regular on-going training, supervision and appraisal.

Is the service caring?

Good ●

The service was caring.

Staff were kind, compassionate and respectful in their approach. People who used the hospice spoke highly of the staff team in all aspects of care and support.

Families and carers received support from the staff during their family member's stay at the hospice and during their period of grief. The hospice provided overnight accommodation for families.

People's end of life choices and wishes were discussed with them sensitively and at the appropriate time.

Is the service responsive?

Good ●

The service was responsive.

Staff had a good understanding of people's care and treatment and how people wished to be supported.

People's care was planned and delivered effectively and emphasis placed on meeting end of life care needs and wishes.

The hospice's medical team provided 24 hour cover so people had access to treatment when they needed it.

A process was in place for managing complaints and complaints were logged and responded to.

Arrangements were in place to seek the opinions of people and their relatives, so they could share their views and provide feedback about the hospice.

Is the service well-led?

Good ●

The service was well led.

The home had a registered manager in post and feedback about

the management team was positive.

There was a clear management structure which helped to promote the management and on-going development of the service.

Staff were aware of the hospice's whistle blowing policy and said they would not hesitate to use it.

We saw a number of quality assurance systems and audits to monitor performance and to drive continuous improvement.

We found that the hospice worked in partnership with other organisations at regional and national level which assisted in the monitoring and development of the hospice service.

Queenscourt Hospice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 31 May, 1 & 2 June 2016 and was announced.

The inspection team consisted of an adult social care inspector, a specialist advisor (SPA) Pharmacist and an SPA with experience in end of life care.

The provider submitted a Provider Information Return (PIR) prior to the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection we reviewed the information we held about the service. We looked at notifications and other information the Care Quality Commission (CQC) had received about the service. We contacted the commissioners of the service to obtain their views.

During the inspection we spent time with four people on the in-patient ward. We spoke with the registered manager, Chaplain for Southport and Ormskirk Trust, a volunteer, therapy staff, two nurses, a unit manager, two members of the care team, two clinical service managers, a quality services manager, the Medical and Education Director (MED) who held the position of consultant in palliative medicine, a doctor and the hospice lead for the transform team. The transform team's remit is to up-skill staff with the knowledge and support for people in the last 12 months of life, both in the community and acute setting. We also spoke with two relatives during the visit.

We viewed a range of records including, four care documents for people who used the service, four staff personnel files, medicine records, records relating to the running of the service and a number of the provider's policies and procedures.

Is the service safe?

Our findings

People who used the service told us they felt safe when receiving care from the staff. People told us, "They (staff) are just marvellous, so good with me and make me feel safe" and "I am a bit unsteady and the staff are here straight away to help me." People told us there were sufficient numbers of staff on duty so they never had to wait for help for help. This they told us made them feel safe knowing someone would come straight away. With regards to staffing levels, people's comments included, "There are always 'bags of staff' around" and "The staffing is excellent." A relative said, "There are always so many staff around on the ward, always checking on the patients. This is so good to see, it's reassuring."

The service had systems to protect people from abuse. A safeguarding policy was in place along with local area safeguarding procedures for staff to follow. The staff had access to a flow chart as guidance for reporting safeguarding concerns. The staff training plan evidenced training in vulnerable adults and children and the role of external agencies. This was given to all staff and the volunteers. Volunteers were also given a hand-out to support their safeguarding learning. We spoke with staff about safeguarding and steps they would take if they were concerned about somebody; the staff gave appropriate responses. A staff member said, "I would not hesitate to speak up if I thought something was wrong." A safeguarding lead was appointed to oversee and monitor safeguarding practices at the service.

We saw how accidents and incidents were recorded and staff told us about the reporting system and actions taken to minimise the risk of re-occurrence, this included discussion about people's individual risks at the staff handovers. For a person who had suffered a fall, staff shared with us the actions taken to minimise the risk of a further fall and the discussions held with the person following the event. Staff told us that if they had concerns about a person they would move them into a more 'observable' area so they could monitor their safety more closely.

Risks to people's safety had been assessed with people's consent and as part of their plan of care. Staff told us that if a person was admitted with confusion or increased risk of falls then a falls risk assessment would be completed. We saw examples of these assessments along with assessments for monitoring nutrition, moving and handling, pain and skin integrity. The risk assessments helped to mitigate those risks and to protect people from unnecessary harm. Fall mats were available for people who had an increased risk of falls; these alerted staff if a person got out of bed. Moving and handling assessments were updated electronically every shift so that any changes were reported immediately. Environmental risk assessments were in place to monitor standards of health and safety. A risk monitoring group assessed whether risk management procedures were effective and whether staff and volunteers were suitably trained to deal with a significant or changed risk.

We looked at the in-patient unit staffing arrangements for the service and saw there were sufficient numbers of staff to meet people's needs. The staff team included senior nurses with qualifications in end of life care to support junior nursing staff. Two nurses were appointed the role of clinical service manager and they worked alongside the unit manager (nurse specialist) to lead the staff team. They along with the quality services manager were also on duty during the inspection.

The registered manager informed us staffing levels were closely monitored and staffing numbers increased to support people with more complex needs or additional staff would be scheduled for 'one to one' nursing. Staff told us the staffing levels were always maintained and any gaps covered by existing or bank staff. Staff comments included, "Excellent staffing arrangements" and "No need to worry at all about the staffing levels and skill mix."

On the first day of our inspection nine people were receiving care on the in-patient unit. The unit manager was on duty with the quality service manager, two clinical service managers, three nurses, two health care workers and ancillary staff which included catering and housekeeping staff. There were also medical staff and other staff in supporting roles such as, volunteers and therapy staff. Therapy staff included a physiotherapist and occupational therapy staff and social worker. The staff team helped to ensure people's physical, emotional and social needs were met. Staff told us there was an 'on call' system for 'out of hours' cover and the registered manager, unit manager and clinical service managers provided this support along with medical staff.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at four staff files and asked the registered manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people. The hospice was supported by a large number of volunteers who undertook multiple roles, for example reception, catering, fund raising and helping with the day service. Volunteers were recruited via the same procedures.

Our pharmacist inspector looked at the way medicines were obtained, stored, prescribed, administered and recorded at the hospice. We found that people were protected from the risks associated with medicines because medicines were managed safely.

During the inspection we spoke with the consultant, a ward doctor, nursing staff and one person about medicines. We talked to the registered manager who was also the hospice's accountable officer about the arrangements for handling controlled drugs (drugs liable to misuse). The accountable officer has a legal responsibility to ensure that controlled drugs were kept secure and safely managed. We found controlled drugs were handled safely. The stock balances of the four controlled drugs we checked were correct. The accountable officer participated in local meetings and submitted reports to the controlled drugs local intelligence network.

We watched nurses administer medicines to three people and saw that a safe procedure was followed. Nurses wore tabards when undertaking medicine rounds to alert people to the fact they were administering medicines to reduce the risk of them being disturbed. One patient said to us "10 out of 10 for the nurses as regards medicines."

Nurses received medicine training and had their competency to administer medicines assessed at least annually. These competency checks included a medicine round competency check, preparing, dispensing and administering controlled drugs and correctly using a syringe driver. A syringe driver enables medicines to be given via a small portable battery operated pump and provides a continuous dose of medicine.

Staff told us that if a person developed uncontrolled pain at night and an increase in their analgesia was needed then the on call doctor would attend. Staff told us rarely would an instruction be given over the phone. In this event two nurses would listen and cross check the accuracy of instruction to ensure the safety of the person receiving the medicine.

The four medicine charts we saw showed that patients received their medicines as prescribed. Doctors followed the hospice's prescribing policy when writing on charts to minimise the risk of misunderstandings and mistakes. Doctors also checked and confirmed people's medicines on first admission to the hospice (a process called medicines reconciliation). When people were discharged they were given detailed, written information about their medicines. The person's GP was contacted the same day to make sure they had up to date information.

There were clear and comprehensive policies and procedures covering the different aspects of medicines management. Medicines were ordered from the local hospital, next door to the hospice. Nurses could obtain medicines seven days per week, if necessary. The hospice was not visited regularly by a clinical pharmacist but staff could phone their designated hospital pharmacist for advice.

Medicines, including medical gases, were stored securely and at the right temperatures. More signs were needed to indicate where oxygen cylinders were kept, for safety reasons. One cupboard used to store controlled drugs did not comply with the relevant legislation. We brought these points to the registered manager's attention and they told us they would action them as soon as possible.

There was a system for recording the receipt of national drug safety alerts and any action taken. For example, in response to an alert about using the drug naloxone written guidance in the form of a flow chart was produced for staff. Nurses also received further training around this. Staff were encouraged to report medicine errors, including those that did not affect patients, so lessons could be learnt and practices made safer. We saw medicine prescription charts were audited (checked) by the consultant to ensure doctors were following the prescribing policy and also audits were carried out of controlled drugs. These checks helped to assure the safe management of medicines.

There was a comprehensive cleaning schedule in place and we found areas seen were clean and hygienic. Staff had access to protective clothing such as, gloves and aprons and we observed staff washing their hands before and after contact with people to help prevent and control the spread of infection. Infection control policies and procedures were available and staff and volunteers received hand washing and infection control training. Infection control was closely monitored by the hospice's infection control lead who attended regional and national events to ensure best practice and to discuss topical issues relating to infection control.

A schedule of planned maintenance ensured the environment was well maintained. Service contracts were in place for services such as, fire system including emergency lighting and fire alarms, Legionella and water treatment, gas and electric service, emergency lighting and portable appliance testing. A fire risk assessment was in place and staff told us they received annual fire prevention training. Other service contracts included moving and handling equipment (hoists and slings) and disposal of clinical waste. The registered manager told us about the night time security arrangements at the hospice; if someone was confused and tried to leave an alarm would sound if there was an attempt to open the exit door.

Is the service effective?

Our findings

People on the in-patient unit told us they received very good care from all the staff team. A person said, "There are so many staff but they all have a role and they tell you who they are and how they are going to help you and make sure you feel at ease". People said the staff were highly trained and able to provide care that was 'right' for them.

We asked people on the in-patient unit to tell us what they thought about the food. A person said, "The food is just like a hotel, so many choices and the cooks come round to ask you what you would like. Nothing is too much trouble for anyone, it's a lovely menu." Likewise another person said, "If you want a glass of wine you can have one, there is a choice of wine and so many lovely meals." People were complimentary regarding the standard, portion size and presentation of the meals.

The hospice offered an in-patient service for people who have life limiting illnesses and who require specialist palliative care. Referrals to the unit were from GPs, a local hospital and the hospice's consultant in palliative care medicine. The registered manager informed us people were admitted to the in-patient unit for symptom and medicine control and to support people and their families with their illness and treatment plans. The average length of stay at the hospice was for eight days with a view to people being able to return to their place of preferred care with the support of Queenscourt at Home staff (aides). When discussing how pleased relatives were with the care, a relative said, "Bringing my (family member) in here was a godsend."

We looked at how people were supported with their nutrition and hydration. People's nutritional needs were assessed and they had a plan of care to support their nutritional needs, requirements and preferences. Staff completed referrals for dietetic support and full cream milk, butter and eggs were used to fortify diets. The hospice had a focus group – Nourishing the Whole Person; this group looked at menu planning, the eating and drinking assessment and making changes to the menu to improve the meal experience for people. A leaflet was available with this information.

We spoke with a cook who told us how they referred to the eating and drinking assessments and how the kitchen staff met with people each day to discuss the menu options. The cook was knowledgeable regarding people's dietary needs and told us the kitchen was open at night so staff could prepare refreshments if people requested something to eat. The hospice's café provided lighter meals which were prepared daily by the staff; this included home-made sandwiches, soups and selection of hot and cold drinks for people, their relatives, staff and visitors. For people who had poor swallowing their food was pureed. Attention was paid to ensuring the correct consistency and using moulds so that components of the meal retained their colour and shape to make the meal more appetising.

We looked at staff training and staff support. We found staff had a very good training programme to support their learning and development.

New staff and volunteers received an induction and were supported by more experienced staff as they became familiar with the service and the provision of hospice care. Staff had a mentor during their four week

induction. The corporate induction provided a detailed overview of the service and what was expected from staff in their new job role. The registered manager informed us new health care workers were enrolled on the Care Certificate. This is 'an identified set of standards that health and social care workers adhere to in their daily working life'. The Care Certificate requires staff to complete a programme of training, be observed by a senior colleague and be assessed as competent within twelve weeks of starting.

Staff had access to a training programme and this was given in accordance with the staff's specific role. Staff attended courses in subjects such as, as manual handling practical and theory, basic resuscitation, hand washing, infection control, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS), equality and diversity, vulnerable adults, medicines, stoma care and mouth care. The majority of training was provided annually, but some courses were refreshed every three years. Staff undertook holistic assessment and care plan training and an end of life skill set challenge. This provided an awareness of end of life care (bronze status), implementation of end of life care (silver status) and influencing end of life care (gold status). Areas covered within the course including, future care planning, symptom control, spiritual care, bereavement, communication skills, eating and drinking and reflective practice. This was completed via on line modules and face to face teaching. Out of 49 staff, 28 had achieved bronze status, 17 silver status and 4 gold status.

Staff also attended a six day palliative care course led by the consultant in palliative care medicine. This course was open to community staff and other external health professionals at the hospice's education centre. Other staff training included wound care, Parkinson's disease and diabetes. A staff member said, "Training and development is on-going, we are encouraged and given opportunities for study and attendance at courses." Staff were encouraged to complete reflection sheets to enable them to reflect on situations that may have been difficult to handle or areas of practice that had gone well.

Evidence based learning was at the forefront of the staff training programme. The registered manager informed us all staff had achieved a formal qualification in care, such as an NVQ (National Vocational Qualification) or equivalent. Formal training in palliative and end of life care was ongoing for clinical staff up to degree/masters level. Two nurses were nurse prescribers which meant they were able to prescribe drugs within their clinical competence. We saw competency checks of staff's clinical competence in areas such as, mouth care and the safe administration of a blood transfusion.

Staff told us they were supported through a good training programme, supervision meetings and an annual appraisal with their line manager. Clinical supervision meetings, support sessions and debrief sessions were held for the staff. We saw records to support this. Nurses were being supported with their nursing revalidation with the Nursing Midwifery Council (NMC). A volunteer told us about the training they had undertaken and we saw the handbook and newsletter volunteers received which outlined the volunteer service.

At this inspection we looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager told us how consent to receive care and treatment at the hospice was established before admission. They told us that if a person was not able to consent to their admission or subsequent care and treatment then a best interest meeting would be held. We saw examples of this in respect of

advance care planning in respect of people's wishes for end of life care. For example, preferred place of care at home and not to be transferred to an acute setting.

We saw examples of DNACPR (do not attempt cardio pulmonary resuscitation) decisions which had been made and we could see the person involved had been consulted and agreed the decision.

Staff were able to talk about aspects of the workings of the MCA and discuss other examples of its use and how someone is deprived of their liberty. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager informed us that at the time of the inspection no applications had been submitted to the 'Supervisory Body'.

We found the registered manager and staff had been trained and prepared in understanding the requirements of the MCA in general and (where relevant) in the specific requirements of the DoLS. Staff had access to policies and procedures for the MCA and DoLS to refer to.

We toured the hospice and found the environment was bright, warm and airy. The in-patient unit had two wards (Lakeside and Woodside) and two single rooms with an option to convert to two further en-suite rooms. The wards were designed to provide maximum privacy by means of small bays with access to a private patio. A bay in each ward could be converted into a single room if necessary. The bay areas were designed so that the doors to the patio areas could be opened wide to allow beds to be wheeled out. The patios also had ample seating space and overlooked well established gardens and a lake. This provided a tranquil setting for people to enjoy peace and quiet.

There were suitable equipment and facilities to meet the needs of people who were receiving end of life care and care after death. People had the use of a call bell for assistance, fully adjustable beds, pressure relieving equipment and use of two adapted baths and bath stretchers. The hospice's facilities ensured sensitive and respectful arrangements were in place for funeral directors to attend and for relatives to spend time with their loved one following death. Other areas seen included a spacious lounge, relative's room, sanctuary room, day therapy department, out-patient department, and offices for co-ordinating Queenscourt at Home.

Is the service caring?

Our findings

People on the in-patient unit were very complimentary regarding the sensitive, compassionate and respectful nature of the staff. Their comments included, "They always tell me to ask for pain relief if I need any", "You can hear them talking to different patients, adapting what they say to whom. It's really good", "When they are giving me a wash, they put a note on the door or lock it", "It's a jolly atmosphere", "They take care of the family as well", "When having a bath, a modesty flannel is applied to protect privacy", "A lovely caring atmosphere", "A haven of calm", "Just amazing staff, they are so wonderful", "I can have my hair and nails done. I just feel everything I need is here", "The care they give is fantastic, that's all the team", "Could not have better, no concerns at all" and "I think it is excellent I have such confidence in the team."

A relative also commented on the very high standard of care and excellent communication from the nursing and medical staff. They appreciated the fact that honest conversations were held but these were delivered sensitively and staff ensured sufficient time was given so that further questions could be asked. They told us they could meet with the nursing and medical staff at any time and that 'nothing ever seemed too much trouble for them'. Another relative commented on the very good medical support given to their family member when they were admitted to the hospice in the evening. They told us the time spent with them was so reassuring. Relatives were able to visit at any time; a relative told us they often came in very early morning and the staff always provided a warm welcome.

The in-patient survey results from March 2015-April 2016 provided a wealth of compliments and high percentage scores for areas which included standard of care, respect, dignity, explanations about care and treatment staffing inspiring people with confidence, meals and volunteer transport. Scores were also high for the Queenscourt aides who provided the Queenscourt at Home service and Queenscourt Connect. A staff member told us how much they enjoyed working at the hospice as it provided such a caring environment.

The hospice had a committed and motivated staff team with a wealth of experience and knowledge to support people with their care and treatment. The Queenscourt Matters newsletter states, 'where life is for living'. The multi-disciplinary staff approach ensured people received their care, treatment and support when they needed it and wished to receive it thus enabling people to enjoy a better quality of life at their preferred place of care.

We saw that the staff valued practice that acknowledged and promoted diversity and equality. Staff told us how they respected people's decisions around their daily life choices and wishes in respect of end of life care. Information was recorded within care documents and staff received training to support this.

The service followed the Priorities for Care of the Dying Person. These are laid out in 'One Chance To Get It Right Report' which staff have a responsibility to follow for end of life care. Staff told us this was 'linked in' with their end of life care training and the principles put into practice. Staff told us about how the needs of families and carers were important to the dying person and they told us about the support groups offered by the hospice. We saw a very caring approach to the wider family. A leaflet was available regarding 'what to expect when someone is dying' and staff told us how they spent time with families to support them through

this emotional time. Support from the hospice staff following the death of a loved one was available via a number of teams. For example, a children and schools support team. 'This service consists of a small number of specialist palliative care professionals who liaise with schools, trying to support children facing or dealing with the loss of someone close to them'. A leaflet for supporting children when a relative is ill, dying or has died was available.

The hospice's chaplain provided spiritual care as this was recognised as being of importance in end of life care and the hospice offered a bereavement service called Stepping Stones. The service was for relatives who were recently bereaved and they were able to attend evenings at the hospice to talk with the staff as a means of support. Staff made contact with next of kin approximately eight weeks after the death of their family member; this service was also open to other family members. Staff were able to offer private appointments as part of the stepping stones support group. Relatives and carers were given leaflets regarding 'what to do when someone dies' and 'grieving, how you may feel when someone you love has just died'. For people who had no family or friends to represent them contact details for a local advocacy service and other support groups were available, along with the specialist support from the staff team.

The hospice held remembrance evenings twice a year and invitations were sent out to relatives who had suffered bereavement. A remembrance book was also available in the sanctuary with the names of people who had received care at the hospice or had an association with the hospice.

The registered manager told us about a new volunteer venture called Queenscourt Outside. This provides a sitting service to enable relatives and carers to have some respite. This has proved to be valuable service for relatives and carers who otherwise may not be able to take a break. Carers' afternoons provide a source of support whereby relative and carers can attend the hospice for a chat and afternoon tea with the staff and enjoy relaxation classes or take part in creative activities. A recent afternoon was well attended and relatives/carers were very complimentary regarding the support and feeling of comfort the afternoon gave.

We observed very positive interactions between the staff and people on the in-patient unit and in other areas of the hospice. People were greeted with a smile and there was a very genuine interest and concern regarding people's care and welfare. When delivering personal care we saw staff adhering to standards which promoted dignity and respect. For example, curtains were drawn around the bed when people were receiving nursing and medical attention and the staff ensured people were not disturbed at this time: staff asked for people's consent before supporting them and waited for people to respond before proceeding: staff took time to listen and did not leave the person until they were comfortable and settled. For a person who was feeling unwell, staff demonstrated an understanding of the symptoms they were experiencing, staff provided plenty of reassurance and comfort. When assessing pain, staff told us the importance of early intervention to ensure this was well managed and pain was assessed on a daily basis to ensure the efficacy of the pain relief.

We saw staff received communication training to help build on feelings of trust and positive working relations between them and the people they supported. Staff training also looked at 'boundary do's and boundary don'ts' to ensure people were treated with respect, dignity and to maintain standards of confidentiality.

There was literature available about the hospice for people and their families to read. This along with information leaflets about various medical conditions and where to seek help from external support organisations was displayed in a prominent place for people to see. Information about the hospice could also be found on their website. There was an overnight room for visitors to use and the hospice also had a house, called Number 7, which was available for relatives to stay overnight or longer. The house provided a

pleasant environment for people to stay and was in close proximity to the hospice.

People said they were consulted about their care and treatment and staff listened and acted on their views. Staff told us how they supported people with what they wished to do or achieve before they died. This was reflected in the care documents we looked at and recorded in an advance care plan (ACP). A leaflet provided people and their families with the information they needed around communicating decisions about future care.

We saw that a number of staff were signed up as a 'dementia friend'. This was to promote an awareness and understanding of the impact of dementia and how staff could help people living with the condition.

Is the service responsive?

Our findings

People on the in-patient unit told the staff provided the care they needed when they felt sick, in pain or anxious. People told us they had no concerns and would not hesitate to speak up if at all worried. A person said, "If I am worried I speak up and staff reassure me and help me." A relative told us the nursing and medical staff kept them informed of medical procedures and any change in treatment.

People were admitted to the in-patient unit at the hospice from their own home, hospital or clinic appointment. The hospice also ran Queenscourt Connect (day service and out patients from 8am to 8pm dependent on clinical need). People attended the day hospice for physiotherapy, occupational therapy, creative and complimentary therapies, social worker input, medical assessment and intervention and out-patient appointments. Queenscourt at home service provided additional support for people who were seriously ill or approaching the end of their life and wished to remain in their own home. The hospice staff worked closely with the district nurse teams, GPs and other community based professionals to provide this support. Staff told us that if they worked in the community they also covered shifts at the hospice so they got to know people in advance of them going home.

The hospice service had links with professional teams such as a heart failure team and crisis intervention team. This team dealt with situations that potentially could prevent someone from staying at home, such as unresolved symptom control or lack of carer support. Staff told us how swift actions were taken by the multidisciplinary team to provide the right level of support so that people could stay in their preferred place of care.

People received care and treatment from a multi health professional team. The hospice had their own consultant in palliative medicine who led a palliative care team at the hospice and worked closely with the local trust and community based staff. The team included doctors and nursing staff who were trained in the administration of palliative medicine and care. A multidisciplinary meeting was held once a week by the consultant in palliative medicine with in-patient and community based staff in palliative care. We attended the meeting for a short period of time to meet other members of the staff team and to find out more how the service operated.

People's consent was obtained for their care and saw that people were involved in decisions about their care and treatment; staff told us they would not proceed without people's full understanding and consent. People's future care wishes were recorded in their care plans. This included where and how people wished to receive their end of life care and their preferred place of care.

The nursing staff ensured that people's needs were assessed and that care and support was planned to support the well-being of people in accordance with their needs and preferences. The assessments took into account different aspects of care such as, personal care, mobility, medical conditions, nutrition, wound care, medicines, pain management, social needs and support for family members.

We looked in detail at the care being provided for four people and gained permission from them to see their

care documents The majority of documents were held electronically with some supporting care documents in paper format. People had a plan of care which provided direction on the type of care an individual may need following the needs assessment. Care plans cover areas such as, as pain control, nausea, vomiting, skin integrity, loss of appetite, constipation, assistance with personal care, psychological support, spiritual care and individualised care at the end of life. Paper formatted care documents were not very detailed however expansion of the care plans was seen electronically and these provided more up to date information about people's care.

End of life care relates to the care provided for a patient anywhere within the last year of life, up to and including death. We saw an example of an individual plan of care of those thought likely to be dying which included pain and symptom management, for example control of nausea and vomiting, family and patient communication. Staff interviewed had a good knowledge of the plan and how it had been implemented with the person involved and their family.

Staff told us how they ensured people and their family members had the opportunity to decide on the advanced care plans (ACP) they wanted to include in their care, such as end of life and decisions about cardio pulmonary resuscitation otherwise known as CPR forms. These were completed in advance with the person and/or family/carer and medical staff. We saw examples of ACPs which had been completed with the person, the hospice staff and family and carers where appropriate. This included a person's preferred place of care or not wishing to be admitted to an acute setting, for example.

We saw the nurses' daily evaluations recorded a detailed overview of the nursing and medical care given over each shift and how people were responding to their treatment plans. A member of the medical team advised us how both nursing and medical staff worked closely together in response to a change in a person's condition or if they experienced episodes of pain or agitation. Staff had access to Telehealth which is an electronic system to support dialogue between health care professionals to discuss and monitor people's conditions. Staff told us this proved a valuable tool when a doctor was not on the premises.

A complaints procedure was in place. In 2015 the hospice received one complaint which was investigated in accordance with the hospice's complaints procedure. Staff told us how they encouraged people to raise any concern with them so that they could sort 'the problem' out immediately.

Is the service well-led?

Our findings

A registered manager was in post and supported by a Board of 13 Trustees, and a senior management team. This included a clinical services team and a non-clinical services team.

People who used the service of the hospice and their relatives told us the hospice was very well managed and that this brought a great deal of comfort to everyone. A person told us, "The hospice has a lovely, friendly atmosphere." A relative said, "The hospice is very well run, everyone knows what they are doing." Staff told us how much they enjoyed working at the hospice and spoke positively about the leadership from senior managers. Staff comments included, "I would not wish to work anywhere else" and "I have learnt so much from working here, it's a privilege to work here." Our observations showed that staff were motivated and passionate in the delivery of palliative and end of life care. We saw evidence of strong team work across all departments so that people received the physical, emotional and social care they needed to achieve the best possible outcome.

The clinical services team were involved with various monitoring and governance groups led by the registered manager and the hospice's consultant in palliative medicine/ medical and education director. This structure included the doctors, clinical services managers, social worker, quality services manager, the education department and other supporting nursing, therapy, catering, housekeeping, administrative staff, Queenscourt Connect and Queenscourt at Home staff. The non-clinical services team was led by a director who also had input into the monitoring and governance groups and was responsible for departments such as, human resource, finance, estates, IT (information technology) and fund raising. This included meetings held by the trustees, clinical services team and non-clinical services team to oversee the governance arrangements in the hospice. The governance structure was well defined to meet its objectives.

At this inspection we looked at quality assurance systems, including audits (checks) and meetings held to monitor performance and to drive continuous improvement. Audits included a review of staff training, medicines, infection control and care plans. 100% was achieved following a recent care plan audit by senior management. This looked at the quality of the information recorded to support people with their care needs. In respect of meetings the trustees met once a month and a link team for the trustees on alternate Tuesdays. We saw the trustees conducted unannounced visits to the hospice and this included looking at the environment and how the service operates from a person's and carer's perspective. Feedback was positive from these visits.

The registered manager and non-clinical services manager met with the consultant in palliative medicine each week to discuss matters arising and review any incidents. Senior management team meetings were also held and sisters' meetings (synergy meetings) held monthly to look at the objectives for 2016 and areas of practice, including falls, staffing, policies and procedures, equipment, the environment, information governance and clinical governance. We saw minutes of a recent synergy meeting and this provided an overview of these areas of practice and a means of sharing lessons learnt with staff. The meeting also provided feedback to staff in respect of a recent on line staff survey. Positive comments had been received around staff support and clinical supervision. We saw minutes of a senior clinical team meeting. This

provided staff with information regarding a policy change following a recent incident to reduce the risk factor and likelihood of re-occurrence.

Senior clinician integrated governance meetings were held every six months and this included an invite to other hospices to promote integrated working in palliative care. Multi professional clinical meetings were held to discuss referrals to the hospice, concerns in respect of people's health and well-being and deaths. We were shown the quarterly clinical results from 2016 and these reported on infection control, prescription charts/syringe drivers, falls, medication incidents and pressure ulcers. Organisational risks were reported to council. The council is the governing body for the hospice. Route cause analysis training was provided for staff to analyse incidents and support completion of risk assessments.

The infection control lead held meetings and attended the Hospice UK infection control meetings. Feedback from these meetings was shared with staff to implement promote learning and to review and update audit tools for monitoring the control of infection. The hospice's infection control steering group monitored standards of infection control in clinical areas and shared information. The hospice's infection control audit annual report for 2015-2016 provided an overview of the infection control audits in four key areas. The environment scored 96%, hand hygiene 100%, waste 100% and sharps 85%. A mattress audit was undertaken to ensure mattresses were fit for purpose and did not promote an infection risk. This showed monitoring arrangements for infection control were effective.

We were shown a number of posters presented by the hospice at national and european conferences regarding the promotion of palliative care and palliative/ end of life training for staff. For example, we saw a poster around promoting clear and precise communication by staff with people who were thought likely to be dying as it had been identified that poor communication could cause distress for people and their families.

The service was proactive in ensuring that people, family members, staff and volunteers were actively involved in the development of the service. These included questionnaires, face to face discussions, carers' meetings, staff meetings and use of social media sites. An eating and drinking survey in May 2016, reported favourably regarding the standard of meals. Comments received from people who used the service at this time included, 'excellent, tasty and well cooked', 'good food well chosen' and 'pleasant environment for meals'. The March 2015-April 2016 in-patient surveys and surveys completed by people using Queenscourt Connect and Queenscourt at Home showed a high percentage of satisfaction for the service giving praise to the staff, the meals, service care, accommodation, and staff's communication skills. Families and carers reported on the peace of mind, comfort and reassurance, awareness of family situations and excellent level of care the Queenscourt aides' home service gave. Discussions with staff showed that people's views were listened to and the registered manager told us how they would form action plans to bring about change to continually improve the service. The registered manager told us how 'patient stories' were to be used in the future as another means of obtaining feedback about the hospice.

Staff told us they understood the concept of whistleblowing and would feel supported if they needed to raise a concern. They confirmed an open culture existed within the hospice.

Staff completed an annual survey in January/February 2016 and results from the clinical and non-clinical themes were shared with the staff. The findings showed that the majority of staff were happy with how the service operated. In response to concerns raised or 'what needs to improve or make a difference' suggestions for improvements were identified. The registered manager told us how these were being actioned and further monitored. We saw staff had access to team briefs and emails, attended meetings and open forum discussions as a means of sharing information. A staff member said "Communication is really

good, all teams work together, we attend regular meetings and are advised of any changes."

During our inspection we found good communication throughout the organisation to support staff in their job role. A framework was in place to offer a more formal route for staff support and this included spiritual support and debrief sessions. These were available on a one to basis or with a group setting. Medical students provided feedback about their placement and they reported how much they had learnt during their placement with teaching 'tailored' to their needs.

We found that the hospice worked in partnership with other organisations which assisted in the monitoring and development of the hospice service. This included the National Council of Palliative Care, the National Association of Hospice at Home and Cheshire and Merseyside Palliative and End of Life Care Network. Staff attended external training events and attended palliative care conferences including those run by Hospice UK to support good practice and further develop standards. Links with a local university had enabled the hospice to contribute to a research based article for an advanced nursing journal regarding experiences and perceptions and those of their families regarding hospice home care. The registered manager also gave us an overview of the trial the hospice were taking part in regarding the evaluation of palliative care services for people with advanced long term neurological conditions.

The hospice's transform team monitored training needs and promoted teaching between hospital, care home and community staff. This included the delivery of the national end of life qualifications - Six Steps Programme and the Gold Standards Framework training programme. This was to support care home staff in the recognition and delivery of end of life care and to support people and their families at this time and through bereavement.

The registered manager was aware of the need to advise us, Care Quality Commission (CQC) of incidents that occurred at the service in accordance with our with our statutory notifications.

All records relevant to the running of the service that we saw were well organised and reviewed regularly.